PERTUSSIS DFA AND CULTURE

State Form 9356 (R2/7-02)
CLIA Certified Laboratory #15D0662599

INDIANA STATE DEPARTMENT OF HEALTH
Microbiology/Rabies Laboratory
P.O. Box 7203
635 N. Barnhill Drive
Indianapolis, IN 46207-7203
Phone (317) 233-8040
Fax (317) 233-8063

PLEASE TYPE OR PRINT LEGIBLY

REQUIRED PATIENT INFORMATION			PLEASE USE BLACK INK Indiana State Department of Health is to mail report to:	
Name (Last) (First)	Age	Sex	Facility Name	
Address			Address	
City IN Zip Code			City IN Zip Code	
Attending Physician			Contact Person	
Address			Phone Number ( )	Fax Number ( )

SPECIMEN INFORMATION				
Date Collected:		Nasopharyngeal (Preferred): ☐ Yes Other (please specify):		
Was the tube incubated prior to shipment? ☐ Yes _____hours ☐ No		Comments:		
COMUNICABLE DISEASE STATISTICS				
Date Of Onset:	Antimicrobial Therapy Begun: ☐ Yes ☐ No	If Yes, indicate drug:	Date Started:	Date Ended:
Pertussis Vaccination: ☐ Yes ☐ No		Dates:		

DO NOT WRITE BELOW THESE LINES

LABORATORY REPORT

PRELIMINARY REPORT:	FINAL REPORT:
Date:	
☐ DFA test NEGATIVE	Test Results for Bordetella: ☐ DFA ☐ Culture
☐ *Bordetella pertussis* ☐ *Bordetella parapertussis*	☐ NEGATIVE ☐ POSITIVE ☐ NO GROWTH
	☐ *Bordetella pertussis* ☐ *Bordetella parapertussis*
☐ DFA test POSITIVE	
☐ *Bordetella pertussis* ☐ *Bordetella parapertussis*	☐ Unsatisfactory
☐ Further studies in progress; final report will follow	☐ Comments
	Lab Number: Date Received:
	Date of Final Report:
	☐ Copy to EPI Resource Center

INSTRUCTIONS

Fill out completely the upper half of the request form on the reverse side. TYPE OR PRINT CLEARLY. The report will be a photocopy returned in a window envelope to the " Name and Address for Report" the patient's physician or other appropriate medical official.

SPECIMEN COLLECTION AND TRANSPORT:

1. To take the specimen, immobilize the patient's head and gently pass the swab through the nostril into the nasopharynx.

IT IS NECESSARY TO OBTAIN TWO SPECIMENS RATHER THAN A SINGLE ONE

2. *Once the specimens have been taken, prepare 4 smears* (2 SEPARATE SLIDES) by rolling the swab to cover the entire circle.

ROLL SWAB TO MAKE SMEAR ON SLIDE

3. Place the swabs in the tube containing the semisolid transport media. Be sure to immerse the swab completely in the media. Snip wire, and re-cap tightly.

LEAVE SWAB IMMERSED IN THE MEDIA FOR TRANSPORT

4. AIR-DRY the prepared slides. Replace dry smears in plastic slide holder (2 per holder).

5. RETAIN THE INOCULATED TRANSPORT MEDIA AT 35 DEGREES C, FOR 18 TO 48 HOURS until ready to transport.

   If unable to incubate, hold refrigerated until ready to package and mail. RECORD THIS INFORMATION on the front of the form within the comments area.

   When ready to ship, put the dried slides into the plastic slide holder and place it and the inoculated transport media into the metal container and secure the screw cap tightly.

   Fold the completed patient submission form in half twice (bottom and top) and roll it around the metal container.
   Insert that into the outer cardboard container and securely tighten the screw cap before mailing.

6. Be sure to give complete patient information including immunization records and antibiotic therapy. DO NOT USE KITS if expired, leaky, broken, or contaminated.

7. It is RECOMMENDED to send the specimen to the laboratory 24 hour-next day delivery. It will insure expedited transport, faster DFA results, and better recovery.

Parasitology

State Form 13053 (R4/5-03)
CLIA Certified Laboratory #15D0662599

INDIANA STATE DEPARTMENT OF HEALTH
Clinical Microbiology
P.O. Box 7203
635 North Barnhill Drive
Indianapolis, IN 46207-7203

Phone (317) 233-8045
Fax (317) 233-8063

Patient's Name (Last)	(First)	Age	Sex
Patient's Address		County	
Attending Physician (if not included below)	Address		

Required Specimen Information

Date Collected_____

First Patient Specimen? ☐ Yes ☐ No

Type:

☐ Feces

☐ _____

_____
(specify)

Purpose:

☐ Diagnostic

☐ Release

☐ Carrier

☐ Outbreak

Other Comments:_____

_____

(Please Print or Type)
Name and Address for Report

_____

_____

_____

_____ IN _____
City Zip Code

Contact Person_____

Phone Number ( )_____

Fax Number ( )_____

Instructions are on the reverse side **LABORATORY REPORT** Do not write below this line

Lab No. _____ Date Received_____ Date of Final Report_____

☐ No trophozoites, cysts, or ova of intestinal parasites found

☐ Comments_____

☐ Unsatisfactory – Please resubmit for reasons below:_____

_____

☐ Copy to ISDH Epidemiology Resource Center

PARASITOLOGY

Submission of Specimens – ISDH Container No. 4A – Intestinal Parasites: Examination of fecal specimens for amoeba and other protozoa. Cryptosporidium sp. will be tested upon request.

IMPORTANT: Mailing container contains one request form, a plastic spoon, and two specimen bottles: one contains 10% Formalin and the other (PVA) Polyvinyl Alcohol fixative.

A. Both solutions are poisonous if taken internally. Do not eat or drink solutions. Any spills should be absorbed with paper towels and discarded as trash. If fluid contacts the skin, wash with soap and water. If fluid contacts eyes, flush with water for several minutes.
B. Kit must be used by the expiration date stamped on the outside of the mailing label. Kits exceeding the expiration date will not be tested. Submitter agencies should return expired kits to the ISDH for recycling.
C. Write **NAME** and **SPECIMEN COLLECTION DATE** on both the **REQUEST FORM** AND **COLLECTION BOTTLES**. Without this complete information the specimen **WILL NOT BE TESTED.**
D. Carefully proceed as follows.

INSTRUCTIONS

1. Fully complete the upper half of the request form. Please type or print clearly.

2. Feces must be added to EACH bottle.

3. Collect feces in a clean bedpan, plate, cardboard container, or paper or plastic cup. (DO NOT MIX URINE WITH FECES)

4. Using the plastic spoon, place a portion of feces the size of a quarter into EACH bottle.

5. Carefully break up and stir the feces in each bottle. Screw the caps on tightly and shake vigorously to further blend the specimen. Place into metal container and tighten screw caps.

6. DISCARD THE PLASTIC SPOON PROPERLY --------- DO NOT return the spoon to the laboratory.

7. Fold and wrap the completed request form *around the outside of the metal container* and place both into outer mailing tube. Tighten screw cap firmly. Mail **PROMPTLY** and unrefrigerated via the U. S. Postal Service (USPS) First Class Mail to the laboratory.

8. The maximum in-laboratory turn-around time for Parasitology specimens is 6 working days. The usual examination time is 1-2 working days after receipt. The submitter should allow sufficient transit time for the USPS to deliver results. Results will be sent as photocopies of the original report.

INDIANA STATE DEPARTMENT OF HEALTH
Clinical Microbiology
Phone (317) 233-8045
Fax (317) 233-8063

Enteric Bacteriology

State Form 13057 (R7/5-03)
CLIA Certified Laboratory #15D0662599

INDIANA STATE DEPARTMENT OF HEALTH
Clinical Microbiology
P.O. Box 7203
635 North Barnhill Drive
Indianapolis, IN 46207-7203

Phone (317) 233-8045
Fax (317) 233-8063

Patient's Name (Last)	(First)	Age	Sex
Patient's Address			County
Attending Physician (if not included below)	Address		

Required Specimen Information

Date Collected_____

First Patient Specimen? ☐ Yes ☐ No

TYPE:

☐ **Feces**

☐ _____

_____
(specify)

PURPOSE:

☐ Diagnostic
☐ Release
☐ Carrier
☐ Contact
☐ Food Service Worker

(Please Print or Type)
Name and Address for Report

_____

_____

_____

_____ **IN** _____
Zip Code

Contact Person:_____

Phone Number: ( )_____

Fax Number: ( )_____

Instructions are on the Reverse Side	**LABORATORY REPORT**	Do Not Write Below These Lines
Lab No.	**Date Received:** Intl:	**FINAL REPORT** **Date:** Intl:

PRELIMINARY REPORT

Date_____ Initial_____

☐ *Salmonella* species isolated. Final identification report will follow.

☐ *Escherishia coli* O157 isolated. Final report will follow.

☐ _____

Comments:

☐ No *Salmonella, Shigella, Campylobacter* or *Escherichia coli* O157:H7 isolated
☐ No Growth on Enteric Media
☐ No *Clostridium* or *Bacillus* sp. isolated
☐ *Clostridium* sp. isolated. Final report from the Reference Laboratory will follow
☐ *Bacillus* sp. isolated. Final report from the Reference Laboratory will follow
☐ *Campylobacter jejuni*
☐ *Escherichia coli* O157:H7
☐ *Salmonella* serotype_____

_____

☐ *Shigella sonnei*
☐ *Shigella*_____Type_____
☐ Unsatisfactory – Please resubmit.
☐ _____

☐ Copy to ISDH Epidemiology Resource Center

ENTERIC BACTERIOLOGY

IMPORTANT INFORMATION

Submission of Specimens – ISDH Container No. 7A – Enteric Bacteriology: Examination of Fecal Specimens for enteric pathogens.

Specimens are routinely examined for *Salmonella, Shigella, Campylobacter,* and *E. coli* 0157:H7. Rectal swabs cannot be examined due to inadequate material. For other enteric pathogens and/or additional information, please call (317) 233-8045.

Before using kit, check the expiration date of the container. **Do not use kit past the expiration date or specimen will not be tested.** If you have expired kits, notify the facility from which they were acquired and request an exchange. Please return expired kits to ISDH for recycling.

The mailing container includes a request form, a spoon for handling the fecal specimen, and one specimen bottle, labeled *Cary Blair.* Do not use this kit if it does not contain the specimen bottle. Feces must be added to the preservative. Handle the bottle carefully to avoid spilling or splashing the contents. Any spills should be absorbed with paper towels and discarded as trash. If the fluid contacts the skin, wash with soap and water. If fluid contacts the eye, flush with water for several minutes. The fluid is not poisonous, but could be an irritant to sensitive individuals. Return any spilled kits to the facility from which they were obtained.

INSTRUCTIONS

7A ENTERIC CONTAINER

PLEASE READ AND FOLLOW CAREFULLY

1. Fill out the upper half of the request form completely including patient name and collection date. **TYPE OR PRINT CLEARLY.** The report will be returned to the health care provider whose address is in the space designated for **Name and Address for Report.**

2. Collect feces in a clean, dry container such as a plastic cup. **DO NOT MIX URINE WITH FECES.**

3. Open the inner container, remove the specimen bottle, and remove the screw cap. Use the plastic spoon to pick up *ONLY TWO HEAPING SPOONSFULL* of solid feces or *FOUR SPOONSFULL IF THE SPECIMEN IS LIQUID.* Place the feces into the open bottle, secure cap *VERY TIGHTLY (write the patient name and collection date on the bottle or the specimen will not be tested).* Replace the bottle into the metal container and secure the metal screw cap firmly.

4. *DISCARD THE PLASTIC SPOON AND REMAINING FECES.*

5. Fold and wrap the completed request form **around the outside** of the metal container and place into the outer mailing tube. Secure lid firmly. Mail or transport **PROMPTLY** and unrefrigerated to the laboratory.

INDIANA STATE DEPARTMENT OF HEALTH
Clinical Microbiology
Phone (317) 233-8045
Fax (317) 233-8063

Enteric Reference Culture
State Form 25601 (R2/5-03)
CLIA Certified Laboratory #15D0662599

Indiana State Department of Health
Clinical Microbiology
P.O. Box 7203
635 N. Barnhill Drive
Indianapolis, IN 46207-7203
(317) 233-8045

Patient Information:

Last First

Name

Address County

Age_____ Sex **M** or **F** Date of Onset_____

Attending Physician_____

Address_____

Name & Address for Report

Required Culture Information:

Source:_____

Date:Isolated:_____Submitted:_____

Suspected Organism

( ) SA ( ) SH ( ) OT

Send Report c/o _____

Phone ( )_____Fax ( )_____

Remarks

_____

_____

DO NOT WRITE BELOW THIS LINE

LABORATORY REPORT

ISDH Lab Number_____ Date Received_____ Final Report Date_____ By_____

Preliminary Report Date_____By_____

( ) *Escherichia coli* 0157 (H7 results pending)

( ) Presumptive_____

( ) Identification in Progress_____

_____

( ) *Salmonella* serotype_____

Serology:_____

group antigenic pattern

( ) *Salmonella*_____

( ) *Shigella sonnei*

( ) *Shigella*_____

type

( ) Negative for *Escherichia coli* 0157

( ) *Escherichia coli* 0157:H7

( ) _____

( ) **Copy to ISDH Epidemiology Resource Center**

ENTERIC
REFERENCE CULTURE

INSTRUCTIONS

1. Submit an 18-24 hour **PURE SINGLE COLONY CULTURE TRANSFER** on a nutrient or infusion agar slant using a screw cap tube.

DO NOT SUBMIT CULTURES IN BROTH OR AGAR PLATES

2. Fill out the request form, front and back, as completely as possible. **TYPE OR PRINT LEGIBLY.** THE NAME OF THE PATIENT AND COLLECTION DATE IS REQUIRED ON BOTH THE TUBE AND FORM. On the front side check probable identification:

SA for Salmonella
SH for Shigella
OT for other

3. Pack the culture securely in an approved container to meet the current transportation (D.O.T.) regulations for mailing infectious substances. Tighten screw caps.

4. The report will be a photocopy of the front side of this form, and returned to the health care provider whose address is in the space designated "Name and Address for Report".

BE CERTAIN THAT YOUR ADDRESS IS COMPLETE SO IT IS RETURNED TO THE SPECIFIC SENDER.

A preliminary report will be forwarded only if there are significant preliminary findings or extended identification studies involved. FAX reports are not routinely sent.

CULTURE INFORMATION FROM SUBMITTING LABORATORY

A. Identification_____

B. Serology Results_____

C. Rapid Method Kit Used ( ) YES ( ) NO

D. Type_____Profile#_____

E. Gram Stain + - Oxidase + -

Other Information or Comments

Indiana State Department Of Health
Clinical Microbiology
Phone (317) 233-8045
Fax (317) 233-8063

Reference Bacteriology Culture Identification

SF 35898 (R3/10-01)
CLIA Certified Laboratory #15D0662599

INDIANA STATE DEPT. OF HEALTH LABORATORIES
MICROBIOLOGY LABORATORY
635 N BARNHILL DR. RM 2023
P.O. BOX 7203
INDIANAPOLIS, IN 46207-7203

REFERENCE BACTERIOLOGY LABORATORY
(317) 233-8040
Fax (317) 233-8063

☐ Mail/Fax Copy of the Report to Communicable Disease

RETURN THIS ORIGINAL FORM WITH THE SPECIMEN, NOT A COPY

REQUIRED PATIENT INFORMATION

Name (Last, First, Middle)			
Address			
Age	Gender	Date of Onset	Physician
Diagnosis			

REQUIRED CULTURE INFORMATION

Isolation Source		Date Isolated	Date Submitted
EXAMINATION REQUESTED		Organism Suspected	
Identification	Confirmation		

SUBMITTER INFORMATON

Facility Name				
Address				
City	IN	Zip Code	Phone Number	Fax Number
Comments:				

DO NOT WRITE BELOW THIS LINE — FINAL REPORT

Comments:		
Lab Number	Date Specimen Received	Date of Final Report

INSTRUCTIONS

The 10A container conforms to all State and Federal laws pertaining to the transport of etiologic agents. If other containers ar used they must also conform to postal laws. The ISDH will reserve the right to refuse and/or discard any specimen(s) received i an inadequate or unsafe container. Submit only **PURE CULTURES** that are to be identified. Mixed cultures may not be accepted It is best to make submissions on a low carbohydrate medium free of excess moisture. For **ANAEROBES** use stab cultures in low carbohydrate medium or sealed chopped meat broth. **FASTIDIOUS ORGANISMS** can be sent as a heavy growth or either blood agar or heart infusion slant.

DO NOT SEND CULTURES ON PETRI PLATES

Complete the top portion of this form. After packing the specimen in the inner container wrap the form around it, insert into th outer container, and affix the screw cap.

Check "**REFERENCE BACTERIOLOGY**" on the container address label to assure prompt delivery to the proper laboratory.

1. The Reference Bacteriology Laboratory services are available to Indiana medical facilities.
2. An effort on the part of the submitting laboratory to identify the isolate must have been made and those results made available to us upon request.

REFERENCE BACTERIOLOGY WORKSHEET

Date Received:	Date Set Up:	Lab Number:

DATE OF OBSERVATION / INITIAL

TEST READ DATE						TEST READ DATE					
TEST SET DATE						TEST SET DATE					

GRAM REACTION/MORPH.						LECITHINASE / LIPASE						
BLOOD REACTION						BILE GROWTH PY						
ATM. REQ. (O_2 / CO_2 /ANO_2 / 5%O_2)						CHOPPED MEAT DIGEST						
COLONY MORPHYLOGY						THIO GEL						
MOTILITY						IRON MILK						
OXIDASE												
CATALASE						CASEIN HYDROLYSIS						
OF FERM CTA						TYROSINE HYDROLYSIS / PIGMENT						
GLUCOSE						TINSDALE HALO						
XYLOSE						COAGULASE RABBIT PLASMA						
MANNITOL						FX 100 / BA 10 / NB 5 / PB 300						
LACTOSE						DNASE / THERMONUCLEASE						
SURCROSE						ONPG						
MALTOSE						PYR						
FRUCTOSE						LAP						
						STARCH HYDROLYSIS						
MacCONKEY						OF FERM CTA						
SS						ADONITOL						
CETRIMIDE						AMG						
SIMMONS CITRATE						AMYDALIN						
CHRISTENSEN'S UREA						ARABINOSE (L)						
NO_3 REDUCTION/GAS						CELLOBIOSE						
NO_2 REDUCTION/GAS						DULCITOL						
INDOLE						ERYTHRITOL						
TSI SLANT/BUTT						GALACTOSE						
TSI H_2S BUTT/PAP						GLYCEROL						
MR						INOSITOL						
VP						INULIN						
GELATIN HYDROLYSIS						MANNOSE						
LITMUS MILK						MELEZITOSE						
PIGMENT						MELIBIOSE						
GROWTH 25°C						METHY-MANNOSE						
GROWTH 35°C						RAFFINOSE						
GROWTH 42°C						RHAMNOSE						
GROWTH °C						RIBOSE						
ESCULIN HYDROLYSIS						SALICIN						
LYSINE DECARBOXYLASE						SORBITOL						
ARGININE DIHYDROLASE						SORBOSE						
ORNITHINE DECARBOXYLASE						STARCH						
NUTRIENT BR. 0% NaCl Growth						TREHALOSE						
NUTRIENT BR. 6% NaCl Growth						TURANOSE						
THAYER MARTIN GROWTH						XYLITOL						
LOEFFLER DIGEST/PIGMENT												
AMYLOSUCRASE												
XV REQUIREMENT												
PORPHYRIN												
ACETAMIDE												
SODIUM ACETATE												
PROPINATE												
ANAEROBIC ALK. NO_3												
PHENYLALANINE/ MALONATE												
BACITRACIN / OPTOCHIN												
BILE SOLUBILITY												
BILE ESCULIN												
6.5% SALT TOLERANCE												
METHYLENE BLUE HYDROLYSIS												
HIPPURATE HYDROLYSIS												
TELLURITE / TETRAZOLIUM												
6 µg VAN/ML GROWTH												

Preliminary ID by GLC Analysis / Date / Initial

_____

Final Identification / Date / Initial

_____

_____

(+)positive (-)negative (A)acid (K)alkaline (pep)peptonization (±)weak,slight positive (d)delayed (S)sensitive growth

(R)resistant growth (IR)indicator reduced (W)weak (NG)no growth (NR)no reaction (mm)millimeter

Mycobacteriology Test Request

SF 13701 (R6/12-03)
CLIA # 15D0662599

	LAST	FIRST	BIRTHDATE	SEX
PATIENT NAME				M F
ADDRESS			COUNTY	
PHYSICIAN		**MD** ADDRESS		

DATE COLLECTED		SPECIMEN SOURCE	ANTI-MYCOBACTERIAL THERAPY
	( ) SPUTUM ( ) CULTURE FOR ID		( ) NONE ( ) STR ( ) ISO ( ) RIF ( ) ETH ( )PZA

Sender Comments	Name and Address for Report

DO NOT WRITE BELOW THIS LINE

MICROSCOPIC EXAMINATION

Auramine-O Stain (400X)
Acid Fast Bacteria
( ) Not Found
( ) Found
( ) < 1 per field
( ) 1-10 per field
( ) > 10 per field

( ) SPECIMEN UNSATISFACTORY

_____

Date_____ By_____

IDENTIFICATION

Mycobacterium
( ) tuberculosis complex
( ) avium complex
( ) chelonae
( ) kansasii
( ) xenopi
( ) fortuitum
( ) gordonae
( ) _____
( ) Not isolated
( ) Culture is contaminated, more time required
( ) Overgrown
( ) Culture sent to CDC
Date_____ By_____

SIRE BACTEC SUSCEPTIBILITY

	µg/ml	S	R
STREPTOMYCIN	2.0		
ISONIAZID	0.1		
RIFAMPIN	2.0		
ETHAMBUTOL	2.5		
PYRAZINAMIDE	100		

S=Susceptible R=Resistant
Date _____
By_____

ISDH COMMENTS

Lab No._____ Date Received _____

( ) Copy to TB Control

☐ FINAL REPORT

MYCOBACTERIOLOGY
(Examination for Tuberculosis)

Complete the top part of the request form. TYPE or PRINT legibly with black ink. The final report will be a photocopy of the front side only, returned to the submitting facility.

Submission of Clinical Specimens
(ISDH Container No. 6A – Tuberculosis)

1. Collect sputum early in the morning BEFORE the patient eats or drinks. It should be raised from the lungs, not saliva, and deposited directly into the furnished plastic container. Do not fill the plastic container more than half full. Wipe off any sputum from the outside of the plastic container before shipment.

2. After collection, tighten the cap to avoid breakage and leakage and place in the metal container.

3. Enclose the completed request form in the outer cardboard mailer along with the aluminum container and forward to the laboratory promptly.

Note: If gastric washings are to be submitted, you must neutralize the washings to about pH 7 within 30 minutes after collection or the organisms will die.

Submission of Cultures

1. Submit a pure culture on a tubed slant of mycobacterial culture medium, preferably Lowenstein – Jensen.

2. Pack the culture to prevent breakage and to conform to USPS and DOT regulations for "Interstate Shipment of Etiological Agents," 49 CFR 173.196. Wrap the culture in absorbent material, place it in an inner container along with the request form and enclose securely in an outer shipping container. Do NOT send or deliver cultures grown on Petri plates; they will not be accepted.

3. The outer shipping container must be marked with the international biohazard symbol. Secure the outer container and write " MYCOBACTERIOLOGY" on the address label to assure prompt delivery to the laboratory.

Test Service Information

1. All samples received with completed paperwork are tested. If there is a problem with your submission, you will be promptly notified by telephone, mail, or both.

2. Drug susceptibly testing procedures are performed on M. tuberculosis only. Drug susceptibility testing on other species may be performed after consultation with laboratory personnel.

a. Bactec 460 S.I.R.E testing requires approximately 1 week too complete. This procedure is automatically performed for new patients and on patients who remain culture positive after 3 months of treatment.

Indiana State Department of Health
Clinical Microbiology
635 N. Barnhill Drive
Indianapolis, IN 46202
Phone: (317) 233-8042
Fax: (317) 233-8043

Mycology Test Request

State Form 6983 (R5/12-03)
CLIA #15D0662599

Date Received_____ ISDH Lab Number_____

Indiana State Department of Health **Clinical Microbiology** **P.O. Box 7203** **635 N. Barnhill Drive, Room 2023** **Indianapolis, IN 46207-7203** (317) 233-8044 SEND REPORT TO:	Patient Last Name First Name M Age Sex **Specimen Information** ( ) Culture for Identification Date Submitted_____ Source_____ Media_____ Suspected Organism_____ ( ) Specimen/Sample Date Collected_____ Date Submitted_____ Type_____
Contact Person: _____ Phone Number: ( )_____ Ext._____	
INITIAL REPORT Date _____ By_____ ( ) Gram Stain Negative ( ) Gram Stain Positive for Fungal Forms ( ) Specimen cultured; allow 2-4 weeks or longer ( ) Culture received; identification in progress	**FINAL REPORT** Date_____ By_____ ( ) Fungus not Isolated ( ) Specimen/Culture Unsatisfactory ( ) Organism(s) Isolated/Identified: ( ) Identified by Exoantigen Test ( ) Identified by GenProbe
PROGRESS REPORT Date_____ By_____	**FINAL IDENTIFICATION**

( ) Copy to Chronic and Communicable Disease

MYCOLOGY

(Examination for Fungi)

INSTRUCTIONS

Fill out the request form as completely as possible. TYPE OR PRINT LEGIBLY. The report will be photocopy of the front side only, returned in a window envelope to the address you transcribe in the "Send Report To" box. The name or ID number of the PATIENT IS REQUIRED.

Submission of Cultures – PROVIDE OWN APPROVED MAILING CONTAINER

1. Submit a pure culture on an agar slant. Use a screw-capped tube only. PETRI DISH OR BROTH CULTURE SUBMISSIONS ARE UNSATISFACTORY AND WILL BE DISCARDED UPON RECIEPT.

2. Pack the culture in absorbent material to prevent breakage and leakage, place in an inner container assuring that it is tightly fastened. Fold and enclose the request form along with the culture securely in the outer mailing container, affix first class postage and mail promptly. All materials must meet the packaging requirements in 49 CFR 173.196 (USPS and DOT regulations for "Interstate Shipment of Etiological Agents").

3. The outer shipping container must be marked with the international biohazard symbol. Please write "MYCOLOGY" on the address label to avoid delays in delivery to the laboratory.